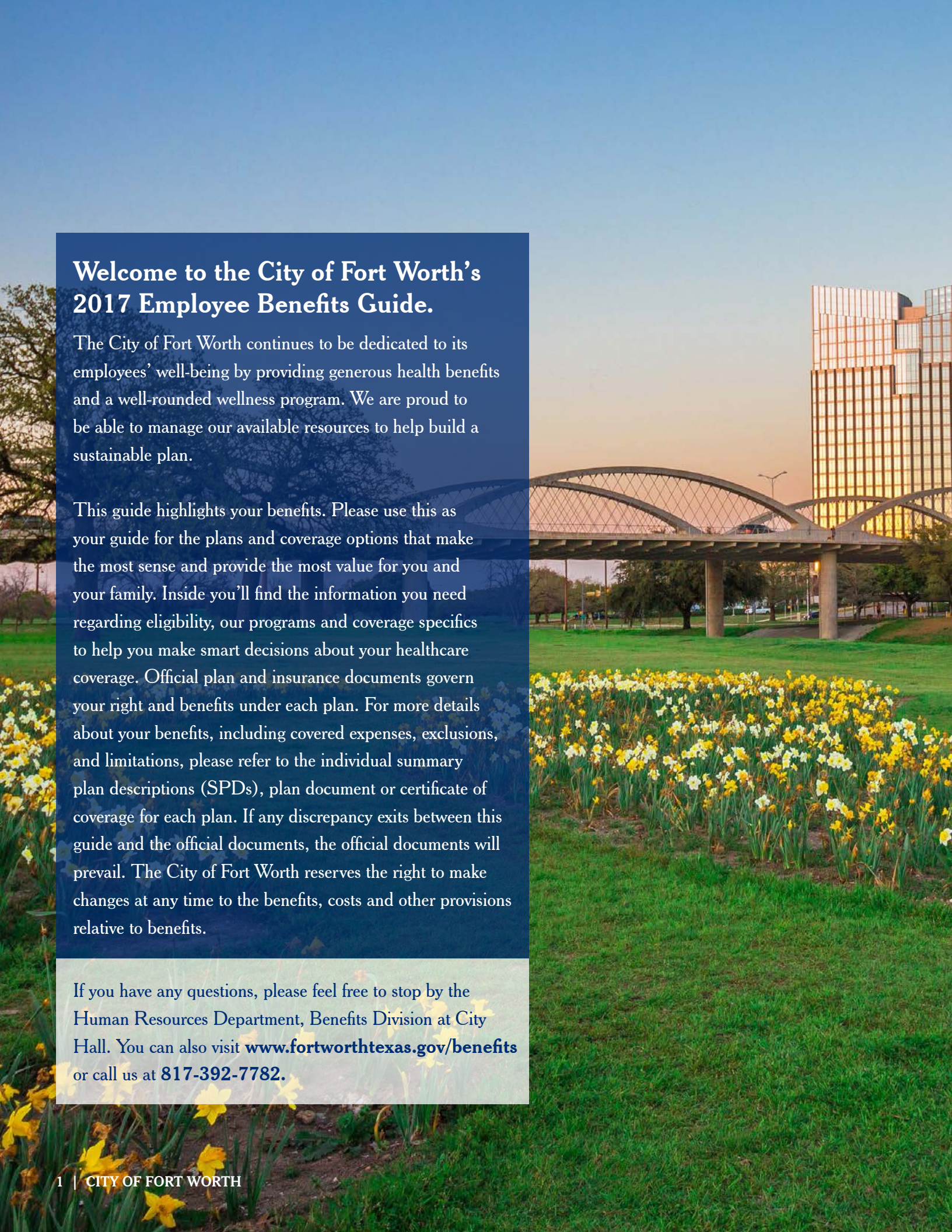
2017

City of Fort Worth
BENEFITS GUIDE

FORT WORTH®



Welcome to the City of Fort Worth's 2017 Employee Benefits Guide.

The City of Fort Worth continues to be dedicated to its employees' well-being by providing generous health benefits and a well-rounded wellness program. We are proud to be able to manage our available resources to help build a sustainable plan.

This guide highlights your benefits. Please use this as your guide for the plans and coverage options that make the most sense and provide the most value for you and your family. Inside you'll find the information you need regarding eligibility, our programs and coverage specifics to help you make smart decisions about your healthcare coverage. Official plan and insurance documents govern your right and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual summary plan descriptions (SPDs), plan document or certificate of coverage for each plan. If any discrepancy exits between this guide and the official documents, the official documents will prevail. The City of Fort Worth reserves the right to make changes at any time to the benefits, costs and other provisions relative to benefits.

If you have any questions, please feel free to stop by the Human Resources Department, Benefits Division at City Hall. You can also visit **www.fortworthtexas.gov/benefits** or call us at **817-392-7782.**

Table of Contents

Important Contacts

TYPE	RESOURCES	PHONE NUMBER	WEBSITE/EMAIL
Medical Nurse Liaison	UnitedHealthcare	844-634-1231 817-392-2668	www.uhc.com www.welcometouhc.com/cfw
Prescription	Envision	Helpdesk 800-361-4542 Mail Order 800-607-6861 Specialty 866-443-0060	www.envisionrx.com
Surgery Option	SurgeryPlus	855-200-9508	www.mysurgeryplus.com/cfw
Dental	Delta Dental	DPPO 800-521-2651 DHMO 800-422-4234	www.deltadental.com
FSA & HSA	Discovery Benefits	866-451-3245	www.discoverybenefits.com
Basic and Supplemental Life & AD&D	Voya/ReilaStar	800-537-5024	To select a beneficiary: https://security.voyaemployeebenefits.com/eSecurity/eBene/login.jsp?group=684121&account=0002
Long Term Disability	Unum	800-858-6843	www.unum.com
Cancer, Critical Illness, Accident	Allstate	800-521-3535	www.allstatebenefits.com
Health Pro Consumer Advocate	Compass	855-769-4377	www.compassphs.com
Musculoskeletal Care	Airrosti	800-404-6050	www.airrosti.com
Near-Site Clinic	USMD	817-566-7466 817-514-7453	www.usmd.com/caretoday-fort-worth.html
New Patient Line Wellness Vendor	VIVERAE	888-848-3723	Connect.viverae.com
Employee Assistance Program	Resources for Living	866-611-2826	www.resourcesforliving.com
Discount Program	BenePlace		www.beneplace.com/cofw
Human Resources	Benefits Office Wellness Office	817-392-7782 817-392-2623	www.fortworthtexas.gov/benefits benefits@fortworthtexas.gov www.cfwnet.org/wellness

About Your Eligibility

If you are a regular **full-time employee** who works 30 or more hours per week, you are eligible for all City of Fort Worth Benefits.

Part-time employees who work 20 – 29 hours per week are eligible for dental, basic life insurance, supplemental life insurance, Flexible Spending Accounts, 457 plan, and Voluntary benefits. Part-time employees who work fewer than 20 hours per week, seasonal, and temporary employees are not eligible for benefits.

DEPENDENTS

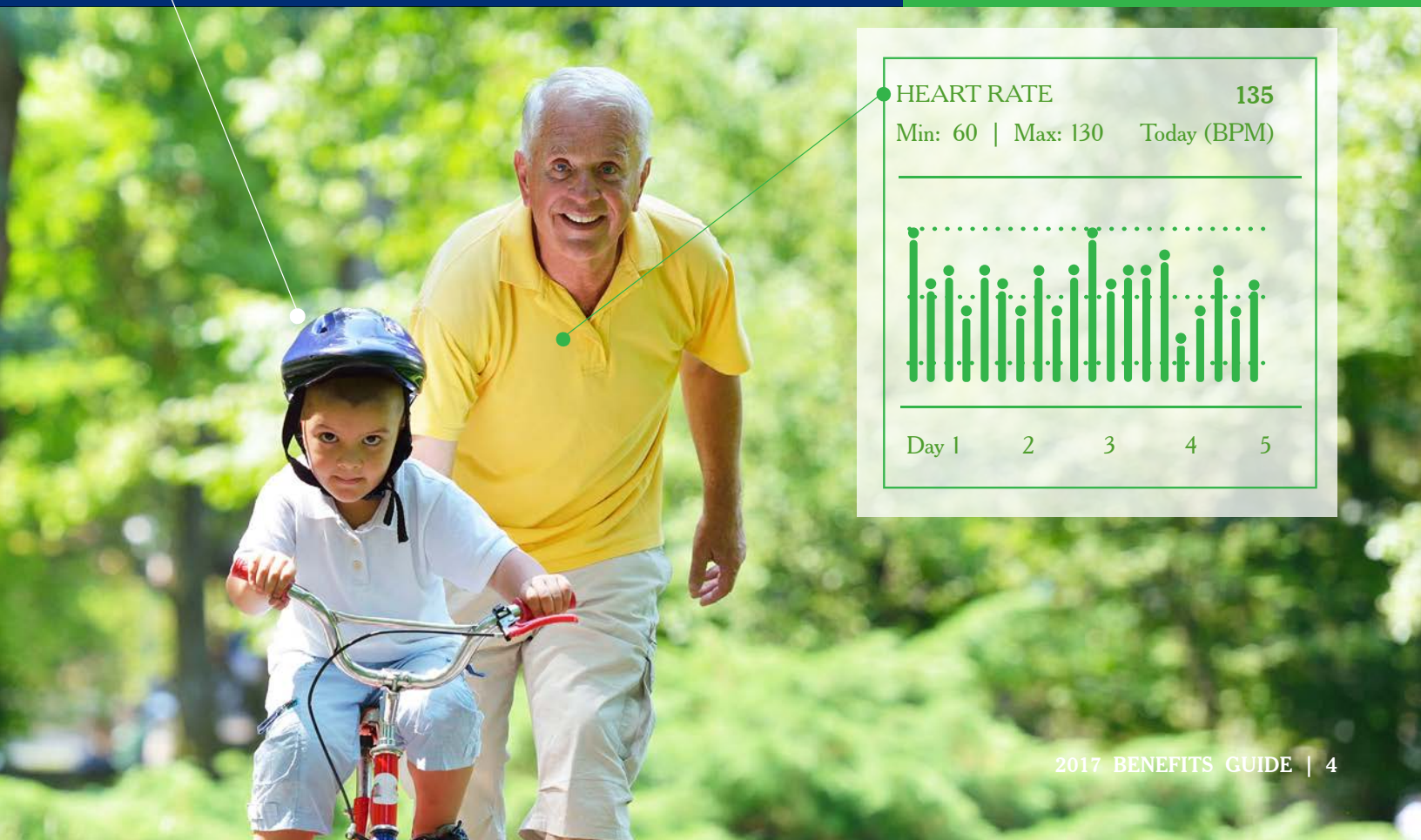
As an employee, you can enroll your spouse, common law spouse, natural child, foster child, stepchild, grandchild, legally adopted child or child under your legal guardianship or custodianship into a plan.

COVERAGE EFFECTIVE DATES

Medical, Dental, FSA and HSA, Voluntary Plans:
One month after date of hire

Basic life, Supplemental Life, and Long Term Disability:
First of the month after 30 days of continuous employment

Pension Plan, 457 Deferred Compensation Plan:
Date of hire



DEPENDENT CERTIFICATION

In order to add your dependents, you need to provide Human Resources with the required forms of proof of relationship status.

DEPENDENT TYPE	ACCEPTABLE FORMS OF PROOF DOCUMENTATION
Spouse	• Marriage License AND • Last year's tax return if married more than 12 months OR • If common law: Declaration and Registration of Informal Marriage. This is available through the County Clerk's Office in the county where you live.
Dependent Child(ren)	• Birth Certificate listing employee or spouse as parent – For stepchildren when not covering the spouse, a marriage certificate and tax return will be requested • If applicable: – Adoption agreement; – Legal guardianship documents; – Divorce decree documents identifying the dependent child; or – Qualified Medical Support Court Order • Disabled dependent child(ren) age 26 or over whose disability began prior to age 26: – A completed dependent eligibility questionnaire verifying an ongoing total disability. – Written documentation from a physician verifying an ongoing disability may be required.

QUALIFYING EVENTS

QUALIFYING EVENT	DEADLINE TO ENROLL OR DIS-ENROLL (W/IN)	CHANGE DATE	REQUIRED DOCUMENTATION
Marriage/Common law marriage	30 days from event date	Date of event	Marriage license; Declaration of Informal Marriage available at the County Clerk's Office in the county where you live
Birth/Adoption	60 days from event date	Date of event	Birth certificate/birth facts document from hospital; Adoption agreement Custody/ guardianship documents
Commencement of employment by spouse or change in hours affecting health insurance eligibility (Gain of coverage)	30 days from effective date of coverage	Effective date of coverage	Offer letter indicating hire date and date benefits begin; Copy of completed enrollment form indicating when coverage begins and that change is due to new hire; or Letter from new company's Human Resources Office
Termination of employment by spouse or change in hours affecting health insurance eligibility (Loss of coverage)	30 days from loss of coverage	Date of loss of coverage	Letter on company letterhead from the previous company indicating when coverage will end. Letter should list the names of all the dependents
Spouse's Open Enrollment Period	30 days from OE period	Effective the Spouse's New Plan Effective Date	Letter or open enrollment guide indicating OE period and effective date of new coverage; and enrollment form or confirmation indicating change made
Death	30 days from date of death	Date of death	Copy of death certificate
Divorce	30 days from date of event	Date of event	Divorce Decree indicating date of dissolution of marriage

Medical Plans

The City of Fort Worth uses these 5 principles to help guide the decisions made about the medical plan(s):

1. **Finding the best care for our employees, retirees and their families**
2. **Better monitoring our employees' health in order to reduce emergency room visits and inpatient days**
3. **Finding physicians that take personal responsibility for the care of their patients**
4. **Improving the health of our employees, retirees and families**
5. **Maintaining a sustainable health plan by reducing the growing cost of health care.**

CHOOSING A MEDICAL OPTION

When it comes to medical coverage, the City offers these choices:

- Basic Plan
- Consumer Choice Plan

Basic Plan (EPO)

The Basic Plan is an exclusive provider organization (EPO) style plan with copayments for office visits. The Basic plan offers in-network benefits only. When you need care go to a United Healthcare in-network doctor or facility. Preventive services including annual check-ups, children's immunizations and an annual Well-Woman exam are covered at 100% with no copay required.

Consumer Choice Plan (HDHP)

The Consumer Choice Plan is a high deductible health plan (HDHP) in which you pay the deductible before the insurance begins to pay. The Consumer Choice Plan offers in-network benefits only. When you need care, go to a UnitedHeatlthcare in-network doctor or facility Preventive services including annual check-ups, children's immunizations and an annual Well-Woman exam are covered at 100% with no coinsurance and the deductible is waived. If you request or your provider does additional testing to diagnose a condition during your annual check-up you will be charged the cost of the additional testing. Employees covered by Tri-Care, Medicare Part A/B, or their spouse's insurance that is not a qualified high deductible health plan are not eligible to participate in the Consumer Choice Plan.

Visit www.welcometouhc.com/cfw for an overview of UnitedHealthcare as well as a plan cost estimator to help you decide which plan is right for you and your family. Enrollment in the Consumer Choice Plan for employees ONLY option is no cost. See page 9.

For the Summary Plan Description and the Summary of Benefits and Coverage including detailed coverage information, limits and exclusions, visit the City's benefit website at www.fortworthtexas.gov/benefits. You can also reach out to Compass, the City's Benefit Concierge Service, at 855-769-4377 for price comparisons and help in finding the right doctor based on your need.

If you are waiving medical coverage please see required notices in the back of the booklet for important information on waiving your medical insurance plan.

2017 Medical Rates Per Paycheck

For active benefits eligible employees

		Completed MHA, Tobacco Affidvait and Physical		Consumer Choice Plan		Completed no requirements	
Basic Plan	Total Cost	Monthly Employee Cost	Employee Cost Per Paycheck	Monthly Employee Cost	Employee Cost Per Paycheck	Monthly Employee Cost	Employee Cost Per Paycheck
Employee Only	$696.82	$104.38	$48.17	$154.38	$71.25	$204.38	$94.33
Employee + Spouse	$1,368.17	$445.86	$205.78	$495.86	$228.86	$545.86	$251.94
Employee + Child(ren)	$1,253.03	$385.34	$177.85	$435.34	$200.93	$485.34	$224.00
Employee + Family	$1,877.41	$602.13	$277.91	$652.13	$300.99	$702.13	$324.06

		Completed MHA, Tobacco Affidvait and Physical		Consumer Choice Plan		Completed no requirements	
Consumer Choice Plan	Total Cost	Monthly Employee Cost	Employee Cost Per Paycheck	Monthly Employee Cost	Employee Cost Per Paycheck	Monthly Employee Cost	Employee Cost Per Paycheck
Employee Only	$548.42	$0.00	$0.00	$50.00	$23.08	$100.00	$46.15
Employee + Spouse	$1,083.91	$266.05	$122.79	$316.05	$145.87	$366.05	$168.94
Employee + Child(ren)	$990.11	$250.83	$115.77	$300.83	$138.85	$350.83	$161.92
Employee + Family	$1,544.90	$375.78	$173.44	$425.78	$196.52	$475.78	$219.59

HEALTH SAVINGS ACCOUNT
Discovery Benefits

If you enrolled in the Consumer Choice Plan, you will use a Health Savings Account (HSA) to pay for health care expenses. The City contributes to your HSA and you can make pre-tax contributions as well. The benefits of the HSA include:

- The City will contribute the lump sum amount of $540 for individual coverage and $1,000 for family coverage up front, prorated for those hired after January 1;
- In addition to the City's contribution, you can contribute an additional $2,860 for individual coverage and $5,750 for family coverage on a pre-tax basis through regular payroll deductions;
- If you are over age 55, you can contribute an additional $1,000;
- Your unused balance rolls over from year to year; and
- It's your money – if you leave the City your account goes with you.

FLEXIBLE SAVINGS ACCOUNTS
Discovery Benefits

The City of Fort Worth offers three types of Flexible Spending Accounts (FSAs) to help you save for out-of-pocket expenses. This money is deducted pre-tax so it will lower your taxable income. These accounts are "use-or-lose", meaning you must use most of your funds by the end of the plan year or you lose the money. You will be able to carry over up to $500 of your FSA Health Account at the end of the plan year to use in the next year.

How a FSA works:

- You can set up a FSA Health Account for eligible health care expenses such as deductibles, copays, coinsurance, prescription drugs, and dental expenses. The maximum you can contribute is $2,550.
- You can set up a FSA Dependent Care Account to help pay for eligible child and elder care expenses so you (and your spouse if married) can continue work or attend school. The maximum contribution is $5,000 per family.
- You can also set up a FSA Adoption Account to cover adoption-related expenses such as legal fees, home-study costs and travel expenses.
- Participants in the Consumer Choice Plan cannot contribute to the Flexible Spending Health Account.

Summary of Plan Benefits

The City of Fort Worth Basic and Consumer Choice plans provide services in the office of a Primary Care Physician (PCP) and Specialist. For purposes of the City's Health Plan, a PCP will be a physician who has contracted with UnitedHealth Care (UHC) as a Primary Care Provider. This will include providers who have contracted as a Family Practitioner, General Practitioner, Internal medicine, Pediatric or OB/GYN provider and are listed in the UHC choice network as a PCP or an OB/GYN provider. All other providers will be considered Specialists. A member is not required to elect a specific PCP and a referral from the PCP is not required to see a Specialist. Below are some general services and your payment amount or percentage. Covered health services can be provided by a Premium Designated Provider at a lower cost.

PLAN FEATURES	BASIC PLAN		CONSUMER CHOICE PLAN	
	In-Network	UHC Premium Designated Provider	In-Network	UHC Premium Designated Provider
Medical Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Annual Deductible • Individual • Family	$950 $1,900		$1,500 $3,000	
Plan Coinsurance Percent the member pays after deductible is met	35%	15%	35%	15%
Facility Coinsurance	20%	20%	20%	20%
Total Out of Pocket Max includes deductibles, copays, coinsurance, prescription deductible, prescription copays • Individual • Family	$5,000 $10,000		$6,250 $10,125	
Physician Office Visit • PCP • PCP at USMD Clinic • Specialist	$45 copay $10 copay $55 copay	$25 copay Not applicable $35 copay	35% after deductible 15% after deductible 35% after deductible	15% after deductible Not Applicable 15% after deductible
Allergy Testing & Treatment Office Visit (Serum/Injections)	$55 copay	$35 copay	35% after deductible	15% after deductible
Routine Physicals/ Immunization • Children * • Adult 18 and older * 1 exam per calendar year • At USMD primary care provider	$0 $0 $0	$0 $0 $0	$0 deductible waived $0 deductible waived $0 deductible waived	$0 deductible waived $0 deductible waived $0 deductible waived

PLAN FEATURES	BASIC PLAN		CONSUMER CHOICE PLAN	
	In-Network	UHC Premium Designated Provider	In-Network	UHC Premium Designated Provider
Routine GYN Exam * 1 routine GYN exam per year with 1 Pap smear & related lab fees	$0	$0	$0 deductible waived	$0 deductible waived
USMD GYN	$0	$0	$0 deductible waived	$0 deductible waived
Routine Mammogram Annual mammogram for females ages 40 & over if at a free-standing lab	$0	$0	$0 deductible waived	$0 deductible waived
Routine Prostate Specific Antigen (PSA) Test & Digital Rectal Exam	$0	$0	$0 deductible waived	$0 deductible waived
Annual DRE & PSA for males age 40 & over				
Colonoscopy • Initial screening ◦ 1 screening every 10 calendar years for individual age 50 & over or with family history • Subsequent Colonoscopy(ies) (Physician charge)	$0 deductible waived 35% after deductible	$0 deductible waived 15% after deductible	$0 deductible waived 35% after deductible	$0 deductible waived 15% after deductible
Refractive Eye Exam (1 exam every 24 months)	$0	$0	$0 deductible waived	$0 deductible waived
Short-Term Rehabilitation Physical, speech or occupational therapy for acute conditions. 60 visits per calendar year.	$35	Not applicable	15% after deductible	Not Applicable
Musculoskeletal Rehabilitation Airrosti Clinic	$15 copay	Not applicable	15% after deductible	Not Applicable
Spinal Manipulation 24 visits per calendar year limited to one visit and treatment per day. Limited to actual spinal manipulation only.	$55 copay	Not applicable	35% after deductible	Not Applicable

Summary of Plan Benefits

PLAN FEATURES	BASIC PLAN		CONSUMER CHOICE PLAN	
	In-Network	UHC Premium Designated Provider	In-Network	UHC Premium Designated Provider
Diagnostic X-ray & Lab • Free-standing facility & services rendered in a physician's office when office visit is not billed	$0	Not applicable	20% after deductible	Not Applicable
• Outpatient hospital	20% after deductible	Not applicable	20% after deductible	Not Applicable
Complex Imaging (MRI, PET & CAT scans) (Facility)	20% after deductible	Not applicable	20% after deductible	Not Applicable
Emergency Room	$350 copay waived if admitted		20% after deductible	
Non-emergency use of emergency room	50% after deductible		50% after deductible	
Ambulance Services Emergency Only	20% after deductible	Not applicable	20% after deductible	Not Applicable
Urgent Care Center	$60 copay	Not applicable	20% after deductible	Not Applicable
Convenient Care Clinic (eg Minute Clinic at CVS)	$30 copay	Not applicable	20% after deductible	Not Applicable
Virtual Visits	$40 copay	Not applicable	15% after deductible	Not Applicable
Convenient Care Clinic (eg Minute Clinic at CVS)	$30 copay	Not applicable	20% after deductible	Not Applicable
Hospital Services • Inpatient	20% after deductible	Not applicable	20% after deductible	Not Applicable
• Outpatient	20% after deductible	Not applicable	20% after deductible	Not Applicable
SurgeryPlus	0% after deductible	N/A	0% after deductible	N/A
Physician Non-Office Visit (Hospital)	35% after deductible	15% after deductible	35% after deductible	15% after deductible
Maternity • Office Visit	$45 copay (copay for initial visit only)	$25 copay (copay for initial visit only)	35% after deductible	15% after deductible
• Delivery Expenses	35% after deductible	15% after deductible	35% after deductible	15% after deductible
Durable Medical Equipment	20% after deductible	Not applicable	20% after deductible	Not applicable

PLAN FEATURES	BASIC PLAN		CONSUMER CHOICE PLAN	
	In-Network	UHC Premium Designated Provider	In-Network	UHC Premium Designated Provider
Skilled Nursing/ Convalescent Facility 60 days per calendar year	20% after deductible	Not applicable	20% after deductible	Not applicable
Home Health Care 60 visits per calendar year	20% after deductible	Not applicable	20% after deductible	Not applicable
Hospice Care 360 days lifetime maximum				
• Inpatient	15% after deductible	Not applicable	15% after deductible	Not applicable
• Outpatient-includes bereavement	15% after deductible	Not applicable	15% after deductible	Not applicable
• Counseling & respite care				
Mental Health & Chemical Dependency Services				
• Inpatient	20% after deductible	Not applicable	20% after deductible	Not applicable
• Outpatient Visit (Physician)	$35 copay	Not applicable	15% after deductible	Not applicable

Diabetes Program

PLAN FEATURES	BASIC PLAN		CONSUMER CHOICE PLAN	
	In-Network	UHC Premium Designated Provider	In-Network	UHC Premium Designated Provider
USMD	$10	Not applicable	15% after deductible	Not applicable
Office Visit at USMD Provider	0%	Not applicable	20% after deductible	Not applicable
Equipment through a DME Provider				
Envision Prescription medications				
- Generic	$0 deductible waived	Not applicable	$0 deductible waived**	Not applicable
- Preferred	$15 deductible waived	Not applicable	50% deductible waived	Not applicable
- Non-Preferred	$50 after deductible	Not applicable	20% after deductible	Not applicable

Prescription Drugs – Envision

PLAN FEATURES	BASIC PLAN	CONSUMER CHOICE PLAN
Annual Rx deductible	$50	
	In-Network	In-Network
• Retail — up to 30 day supply - Generic - Preferred (formulary) - Non-Preferred (non-formulary)	 100% after Rx deductible & $10 copay 100% after Rx deductible & $30 copay 100% after Rx deductible & $50 copay	 20% after deductible*** 20% after deductible**** 20% after deductible
• Specialty	20% after deductible To a maximum of $200/script	20% after deductible
• RX90 Maintenance Medications — Walgreens/Envision Mail Order - Generic - Preferred (formulary) - Non-Preferred (non-formulary)	 100% after Rx deductible & $25 copay 100% after Rx deductible & $75 copay 100% after Rx deductible & $125 copay	 20% after deductible 20% after deductible 20% after deductible
• Wal-Mart/Sam's Club — up to 30 day supply - Generic - Preferred (formulary) - Non-Preferred (non-formulary)	 100% after Rx deductible & $5 copay 100% after Rx deductible & $25 copay 100% after Rx deductible & $45 copay	 20% after deductible 20% after deductible 20% after deductible
• Wal-Mart/Sam's Club — 90 day supply - Generic - Preferred (formulary) - Non-Preferred (non-formulary)	 100% after Rx deductible & $15 copay 100% after Rx deductible & $75 copay 100% after Rx deductible & $135 copay	 20% after deductible 20% after deductible 20% after deductible

NOTE:

* Assumes service is provided by a primary care physician (PCP) per National guidelines

** On specific medications only

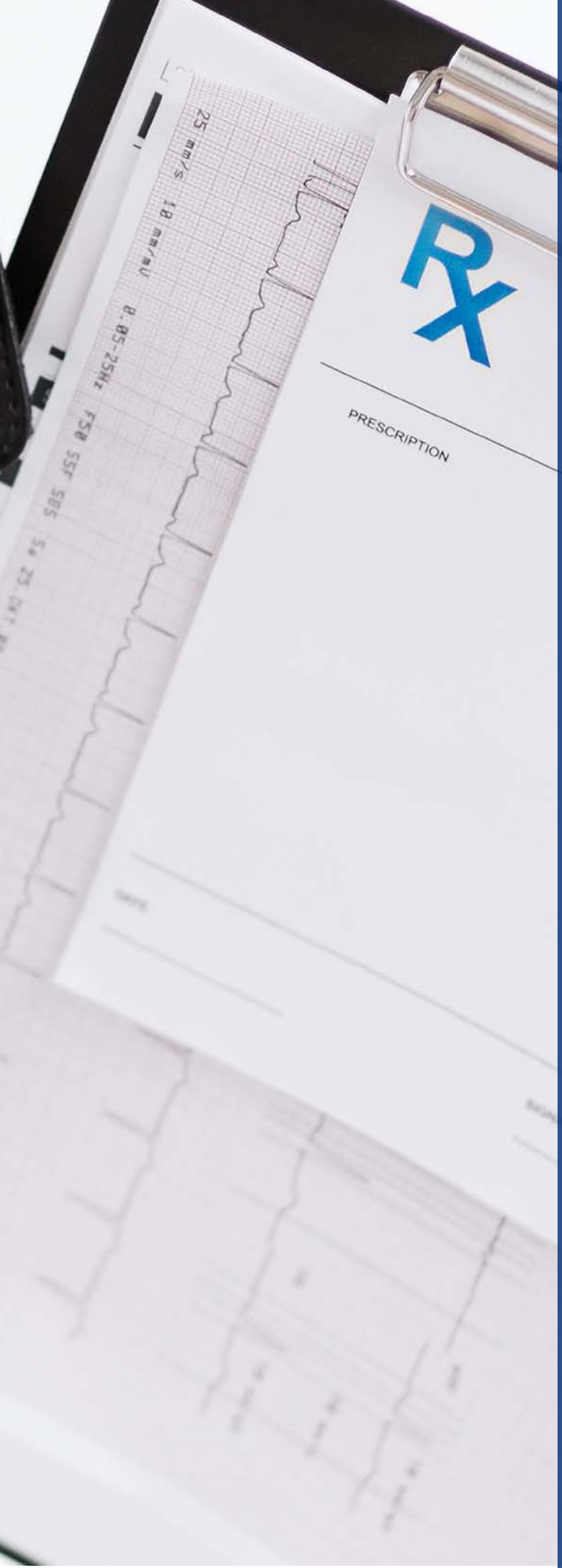
*** Certain generic preventive maintenance medications are covered at 100% deductible waived

**** Certain preferred preventive maintenance medications are covered at 50% deductible waived

A PCP can be a general practitioner, family practitioner, internal medicine, pediatrician, an OB/GYN.

Only one copay will apply per office visit.

THE SUMMARY PLAN DESCRIPTION PROVIDES A MORE DETAILED DESCRIPTION OF EACH PLAN



RETAIL PRESCRIPTION PROGRAM
EnvisionRX

The retail prescription program uses a network of participating pharmacies. To receive the highest level of benefits, you must use a participating pharmacy. Prescriptions you fill at non-participating pharmacies are generally not covered. If you enroll in the City's medical plan, you will automatically receive prescription drug coverage.

MAINTENANCE MEDICATION
RX90 Program

For people who take maintenance medication for **chronic conditions**, you have to use the RX90 program to fill your prescriptions. You can go to Walgreens or use EnvisionRX mail order for medication to treat chronic conditions such as arthritis, asthma, diabetes, high cholesterol, high blood pressure and other chronic conditions.

Medications that are available over the counter (OTC) are not covered by Envision and generic medications are mandatory. You will need a physician's letter of need to receive the brand name.

NEAR-SITE CLINIC
Care Today USMD

The City offers **eight near-site clinics** across the Metroplex to make it easier and less expensive for you to receive care when you are sick. The clinics offer same - or next-day appointments to treat conditions such as flu, cold, stomach ache, ear aches, sinus troubles, etc. For those on the Basic Plan the copay is only $10; for those on the Consumer Choice Plan, the coinsurance is 15% after the deductible.

DENTAL PLANS
Delta Dental

The City continues to offer 4 dental coverage options:

- A dental DPPO high option
- A dental DPPO low option
- A dental DHMO high option; and
- A dental DHMO low option

The dental HMO plans have **limited networks** and are limited to those residing in certain zip codes. The DHMO low option plan is only available to employees and enrolled dependents who live in the state of Texas; there is no coverage for dependents residing outside of Texas. On the DHMO plan, you choose a primary care dentist who will direct your care. There is no maximum the dental insurance will pay on the DHMO plan. On the DHMO high option, all services are paid on a copay basis. On the DHMO low option, all services done by a general dentist are paid on a copay basis, but for those services done by a specialist, you would pay a discounted rate.

The DPPO plans allow you to see **any dentist** in or out of network, but there is a limit to how much the dental insurance will pay which includes services such as cleanings and x-rays. You can receive four cleanings per calendar year on both the high and low DPPO options. Orthodontics are only covered on the high DPPO option and implants are covered on both options to the plan limit.

2017 Semi-Monthly Dental Rate

For active full time, part time employees and council aides

DPPO Plan		
	DPPO High	DPPO Low
Employee Only	$14.74	$9.93
Employee + Spouse	30.21	$18.86
Employee + Child(ren)	$39.05	$21.84
Employee + Family	$49.36	$30.78

DHMO Plan		
	DHMO High	DHMO Low
Employee Only	$6.77	$4.57
Employee + Spouse	$11.66	$7.83
Employee + Child(ren)	$13.55	$8.15
Employee + Family	$20.67	$12.19

Delta Dental www.deltadentalins.com
DPPO 800-521-2651
DHMO 800-422-4234

	DELTACARE PREPAID (DHMO)		DENTAL PPO (DPPO)	
	DHMO – Low Option	DHMO – High Option	DDPO – Low Option	DDPO – High Option
Deductible	None	None	$50 / person $150 / family	$50 / person $150 / family
Annual Maximum	None	None	$1,000 / person	$1,500 / person
Provider	Member must use participating provider	Member must use participating provider	Unlimited PPO network available	Unlimited PPO network available
Preventative & Diagnostic Care	You pay fixed copayments according to the plan's schedule of benefits	You pay fixed copayments according to the plan's schedule of benefits	Plan pays 100% with no deductible	Plan pays 100% with no deductible
Basic restorative Care	You pay fixed copayments according to the plan's schedule of benefits- Specialists referral is required under this plan.	You pay fixed copayments according to the plan's schedule of benefits- Specialists referral is required under this plan.	Plan pays 50%	Plan pays 80%
Major restorative Care	You pay fixed copayments according to the plan's schedule of benefits- Specialists referral is required under this plan.	You pay fixed copayments according to the plan's schedule of benefits- Specialists referral is required under this plan.	Plan pays 50%	Plan pays 50%
Orthodontics **Life-time maximum**	You pay fixed copayments according to the plan's schedule of benefits.	You pay fixed copayments according to the plan's schedule of benefits.	N/A	Plan pays 50%
Implants	Not covered	Not covered	Play pays 50%	Plan pays 50%
Additional Information	When referable services are provided by a contract specialist including an oral surgeon, endodontist, periodontist or pediatric dentist, the enrollee pays 75% of that dentist's "filed fees."		You may be billed the balance for going to a non-Delta Dental PPO network dentist. You will be billed the difference between the PPO fee and the Delta Dental Premier dentist fee or the Out-of-Network dentist fee.	You may be billed the balance for going to a non-Delta Dental network dentist.

SURGERY

SurgeryPlus

The City of Fort Worth is pleased to offer SurgeryPlus. SurgeryPlus helps you plan and pay for non-emergency surgeries. When you use SurgeryPlus you could **save significantly** on surgical procedures. This great new benefit is automatically available to participants enrolled in the City of Fort Worth's medical plans.

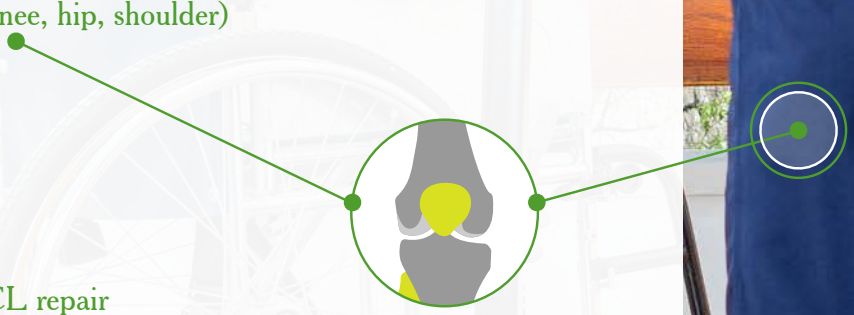
How it Works:

- When your doctor recommends surgery, call SurgeryPlus at 855-200-9508.
- A personal Care Coordinator will help you find a high-quality, board-certified surgeon. The Care Coordinator will then assist you throughout the entire process, from scheduling the initial consultation all the way to post-procedure follow-up.
- SurgeryPlus negotiates all of the costs before you have surgery and handles the payment process for you.
- For members who use SurgeryPlus, The City of Fort Worth will pick up the entire cost after you meet your deductible!

COVERED SURGERIES:

A complete **list of surgeries** available can be found by visiting www.mysurgeryplus.com/cfw or by calling a Care Coordinator at 1-855-200-9508. Some covered surgeries include:

- Orthopedic - (i.e. knee, hip, shoulder)
- Hysterectomy
- Hernia repair
- Rotator cuff repair
- Knee arthoroscopy
- Bunionectomy
- ACL, MCL or PCL repair
- and many more!



WELLNESS PREMIUM DIFFERENTIAL

The City offers a premium differential for those who complete three activities through the VIVERAE portal. The activities are: complete a Member Health Assessment (MHA), complete the tobacco affidavit (if a non-user) or complete the four week Break Free from Tobacco online program through the VIVERAE portal, receive a screening physical and submit the Physician Screening Form (PSF). As a new hire, if you are hired prior to 6/1/17, you will need to complete these activities by 8/31/17 for the 2018 plan year. If you are hired 6/1/17 or later, you will need to complete these activities in 2018 for the 2019 plan year.

The Member Health Assessment (MHA) is required to receive any incentive at all. Those that complete all three activities will receive a $100 monthly premium differential. Those that complete only the MHA and either the tobacco affidavit/program or MHA and Physical will pay $50 more per month. Those that do none of the three activities, or do the physical and the tobacco affidavit/program but do not complete the MHA will pay $100 more per month.

For those enrolling a spouse into the Medical plan, the spouse is also required to complete these three activities in order to pay the lowest premium possible.

HEALTHY CHALLENGE PROGRAM

By completing three activities (MHA, tobacco affidavit/program, physical), employees are automatically enrolled into the wellness program and earn points towards the annual wellness payout in January. Employees can then complete other activities (either online or in person) to earn up to 250 points which translates to a maximum of $250 per year.

The website for VIVERAE is connect.viverae.com. Your identifier is your Employee ID and your Registration Code is FortWorth.

MUSKLOSKELETAL REHABILITATION

Airrosti

Airrosti provides a unique approach to reduce prevalence and incidence of musculoskeletal conditions. Most often clients obtain **relief in about 3 visits.**

Conditions they treat include:

- Acute injuries/musculoskeletal conditions
- Chronic joint and soft tissue injuries
- Patients seeking an alternative to surgery
- Patients not receiving lasting relief from steroid injections and other pain management interventions
- Unresolved rehab patients
- Post-surgical patients with persistent symptoms

Common injuries they treat include:

- Back pain
- Neck pain
- Headaches
- Triceps
- Tendonitis
- Disc injuries
- Hip pain
- Sciatic-like pain
- Achilles Tendonitis
- Carpal Tunnel Syndrome
- Knee pain
- Shin Splints
- Plantar Fascitis

HEALTHCARE CONCIERGE

Compass Professional Health Services

Compass Professional Health Services is the City's employee advocate for health services, including:

- Bill review to audit and to resolve incorrect health service bills
- Price-transparency analysis to compare prices for providers, services and prescriptions
- Provider selection of physicians, hospitals and other service providers based on quality and member preferences
- Additional concierge support such as appointment scheduling, collection of medical records and coordination of services

LIFE INSURANCE – VOYA/RELIASTAR

Basic Life Insurance and Accidental Death & Dismemberment (AD&D)

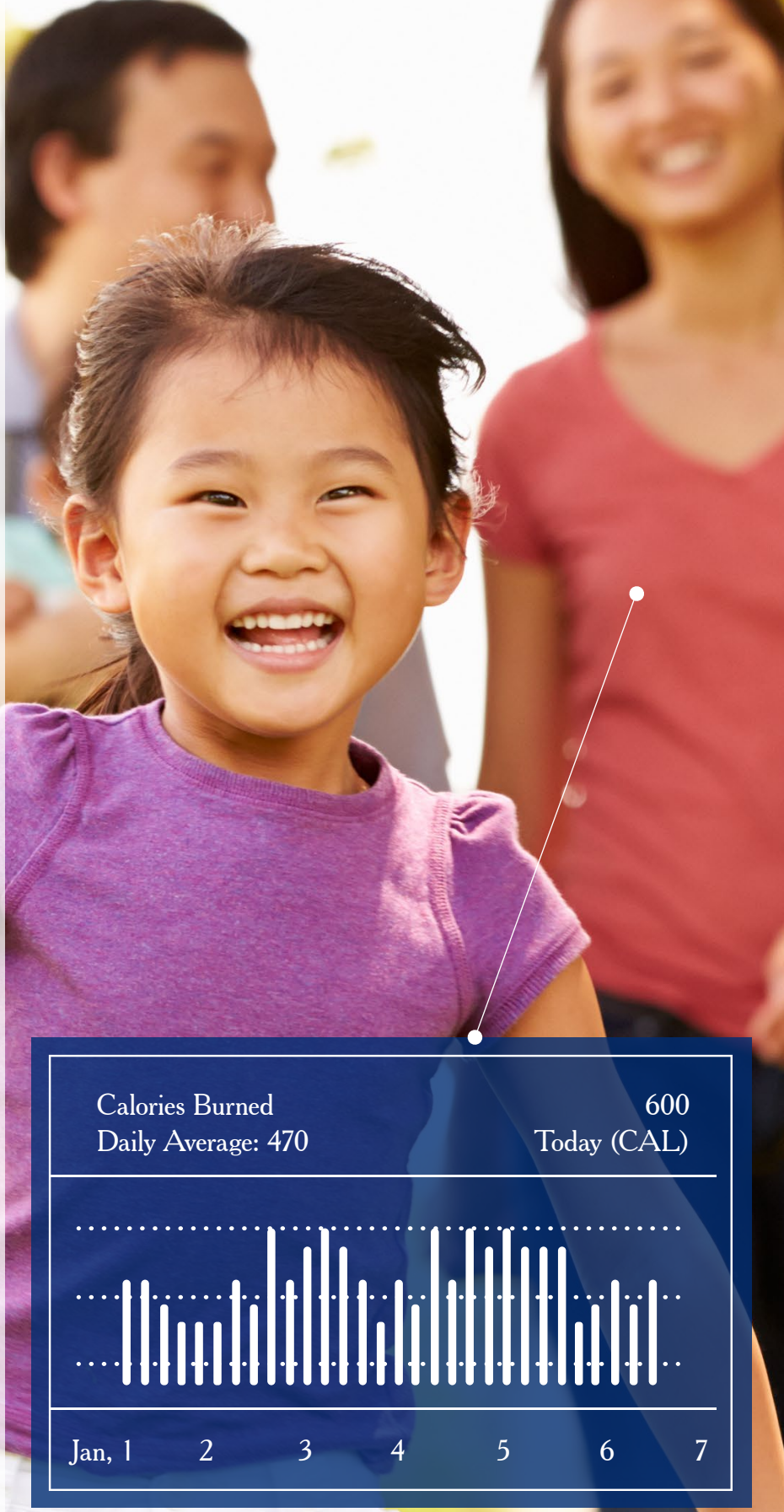
The City provides you with basic life and accidental death and dismemberment insurance in the amount equal to your annual salary.

Supplemental Employee, Spousal and Dependent Life & AD&D

You can purchase Supplemental Group Term Life insurance for yourself and your family. Group Term Life Insurance provides you with **lower rates** and the ability to take your coverage with you if you leave the City or retire. To purchase coverage for your dependents, you must purchase supplemental coverage for yourself.

Policies are available in amounts up to five times your annual salary. You may enroll your spouse in a flat $50,000 policy and each of your dependent children is eligible for a $10,000 policy. Newborns to age 14 days are eligible for $750 in coverage. This amount automatically increases to $10,000 on their 15th day of life.

As an added benefit, employees who purchase Supplemental Group Term Life insurance also receive additional **travel assistance** for emergencies as well as funeral concierge services to help in planning services.



LONG TERM DISABILITY (LTD)
UNUM

Long-term disability insurance provides income replacement in the event you are unable to work due to your own accident or a serious medical condition. To be eligible to enroll in long-term disability, you must be an **active employee** and regularly work 30 or more hours per week.

You may choose coverage that replaces either 40% or 60% of your pre-disability earnings. The maximum monthly benefit is $6,000 for the 40% option or $9,000 for the 60% option. You also choose a waiting period – the amount of time you must wait after being declared disabled to collect benefits – of 90 or 180 days. The longer the waiting period, the lower the cost of coverage. Total cost of premiums also will depend on your annual salary, age and percentage of coverage you select.

VOLUNTARY LEAVE BANK

The City of Fort Worth offers a Voluntary Leave Bank that provides up to **240 hours** of continued income after you've exhausted all of your accrued leave. The hours are provided if you are required to miss work due to a personal medical emergency or to care for an immediate family member who has had a medical emergency.

If you are a first-time enrollee, four hours of vacation time will be deducted from your leave accrual once you have completed your probationary period. Each subsequent year you are enrolled, one hour of vacation is deducted from your total each January.

EMPLOYEE ASSISTANCE PROGRAM
Resources for Living

Through the Employee Assistance Program (EAP), at no cost to you, you and eligible members of your household have 24/7 access to up to six free confidential counseling sessions to help you address issues such as relationship problems, drug and alcohol abuse, depression, stress and financial hardships. Many issues can be addressed directly with your EAP professional; in some cases, you may be referred to other resources. Additional sessions will need to be coordinated with your health plan.

457 DEFERRED COMPENSATION PLAN
TIAA-CREF

The City of Fort Worth offers you a Deferred Compensation, or 457 Plan, to make saving for your retirement easier and more convenient. You may contribute on a pre-tax or a post-tax Roth basis. The Plan offers a range of high and lower risk investment options, including target retirement date funds that are actively managed with a goal retirement date in mind. A brokerage account also allows you to invest in hundreds of mutual funds. You may contribute up to the IRS limits each year and change your contribution amount and/or investment allocations online any time.

The 457 Deferred Compensation Committee monitors the performance of the plan. The Committee meets quarterly and meetings are open to the public.

EMPLOYEE DISCOUNTS/VOLUNTARY BENEFITS
BenePlace

Through the BenePlace website, you can purchase items and tickets at discounted rates. Tickets include such local options as Six Flags Over Texas, the Fort Worth Zoo, Legoland Discovery Center and discounted movie tickets. If planning a vacation, you can also find discounted amusement park tickets for parks nationwide as well as discounts on cruises and hotel stays.

BenePlace also offers discounts on items for your home, sporting equipment, dining, electronic or services for your car. You can also purchase supplemental benefits through BenePlace. Current offerings include: vision, pre-paid legal, home and auto insurance, AllState (coming April 2017), pet insurance and identity theft coverage. You can enroll online through BenePlace website.

CITY OF FORT WORTH GROUP HEALTH PLAN

WAIVER OF COVERAGE

You may decline health coverage offered by the City of Fort Worth's (Employer) group health plan. This is called a waiver of coverage. If you waive coverage for yourself, you may not cover dependents under the Employer's group health plan.

Note that after 2013, if you decline coverage considered affordable and minimum essential under the Patient Protection and Affordable Care Act ("ACA"), you will not qualify for government credits and subsidies to purchase individual health insurance on the Marketplace. The decision to waive coverage has consequences for you. For example:

- You should be aware of the individual shared responsibility requirement that took effect on January 1, 2014 under the ACA. If you refuse the offer of the Employer's group health coverage and do not obtain coverage on your own, you will be subject to a penalty. Please consult a licensed tax professional for further details regarding how you may be impacted under the ACA.

- Unless you sign a waiver stating that you/your dependents are covered under another plan, such as a spouse's plan, Medicaid, or Medicare, you cannot enroll in the Employer's health plan until the next open enrollment. However, if you are covered under another plan, but that coverage is lost, you can enroll in your Employer's health plan immediately. There's a time limit for enrolling after the other coverage is lost: you must request to enroll in your plan within 30 days of losing the other coverage.

- If you gain a new dependent through birth, adoption, placement for adoption, or marriage, you may enroll yourself, the new dependent, and the entire family at that time, but you must do so within 30 days of gaining the new dependent (60 days for birth, adoption, or placement for adoption). If you miss the enrollment deadline, you must wait until open enrollment.

COBRA

You are receiving this notice because you have recently gained coverage under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group coverage would otherwise end. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event, known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to The City of Fort Worth Health plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of any of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- For retirees, commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator in writing within 30 days after the qualifying event occurs. You must provide this written notice to: City of Fort Worth, Benefits Office 1000 Throckmorton, Fort Worth, TX 76102

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of ours of work. Certain qualifying events, or a second qualifying event during this initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in writing and in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact Discovery Benefits at 888-408-7224 within 60 days of the date of determination of disability.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less the COBRA continuation coverage. You can learn more about many of these options at www.Healthcare.gov.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employment Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

COBRA PLAN CONTACT INFORMATION

Discovery Benefits
4321 20th Ave S.
Fargo, ND 58103
Phone: 888-408-7224

NOTICE OF PRIVACY PRACTICES

REVISED DATE: AUGUST 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes how your group health plan, the City of Fort Worth Employee Health Benefits Plan (the "Plan"), may use and disclose your health information to carry out payment, health care operations and other purposes that are permitted or required by law. This health information may be recorded in your medical record, invoices, payment forms, videotapes or other ways. This notice also describes your rights to limit access

to your health information and the Plan's responsibilities under federal and state laws. Health Information is any information (whether oral or recorded in any form or manner) that is created or received by a health care provider, the Plan, a public health authority, a health care clearing house, or The City ("Employer") and relates to the past, present, or future physical or mental health condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

THE PLAN'S RESPONSIBILITIES

The Plan is required by law to maintain the privacy of your health information and to provide you with this Notice of its legal duties and privacy practices. In addition, the Plan is required to abide by the terms of the Notice currently in effect. The Plan reserves the right to change the terms of this Notice and to make those changes applicable to all health information that the Plan maintains. Any changes to this Notice will be posted in the Benefits department of the Plan Sponsor, and will be available upon request.

PRIMARY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

In certain circumstances, the Plan is allowed or may be required to use or disclose your health information without obtaining your prior authorization and without offering you the opportunity to object. The most common uses or disclosures of your protected health information include:

- **Treatment.** The Plan may use or disclose your health information for the purpose of providing, or allowing others to provide, treatment to you. An example would be if your primary care physician discloses your health information to another doctor for the purposes of a consultation. Also, the Plan may contact you with appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- **Payment.** The Plan may use or disclose your health information to allow the Plan or other companies to pay claims or receive payment for the health care services provided to you. For example, the Plan may disclose your protected health information when a provider requests information regarding your eligibility for coverage under the Plan.

- **Health Care Operations.** The Plan may use or disclose your information for the purposes of the Plan's day-to-day operations and functions including, but not limited to quality assessment, reviewing provide performance, licensing, and stop-loss underwriting. For example, the Plan may (1) compile your health information, along with that of other patients, in order to allow a team of the Plan's health care professionals to review that information and make suggestions concerning how to improve the quality of care provided by the Plan; (2) the Plan may disclose or use your health information to answer a question from you, or (3) the Plan may use your information to determine if a treatment that you received was medically necessary.

- **Plan Sponsor.** The Plan may disclose your protected health information to the Plan Sponsor of the Plan, The City, to administer the Plan or if you sign an authorization to do so.

OTHER POSSIBLE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The Plan is required by law to maintain the privacy of your health information and to provide you with this Notice of its legal duties and privacy practices. In addition, the Plan is required to abide by the terms of the Notice currently in effect. The Plan reserves the right to change the terms of this Notice and to make those changes applicable to all health information that the Plan maintains. Any changes to this Notice will be posted in the Benefits department of the Plan Sponsor, and will be available upon request.

- **Required by Law.** The Plan may use or disclose your health information when required to do so by federal, state or local law. Examples include:

- **Public Health Activities.** The Plan may use or disclose your protected health information for public health purposes that are allowed or required by law. For example, we may use or disclose information to a public health authority to report diseases, injuries, or vital statistics, or reactions to medications or problems with products or to notify people of recalls of products they may be using, or who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

- **Abuse or Neglect.** The Plan may use or disclose protected health information to a government authority about victims of abuse, neglect, or domestic violence;

- **Health Care Oversight Agency.** The Plan may disclose protected health information to a health oversight agency for activities authorized by law. These oversight activities include, but not limited to, audits, investigations, inspections, licensing procedures, or civil, administrative, or criminal proceedings or actions. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws;

- **Legal Proceedings.** The Plan may disclose your protected health information for judicial or administrative proceedings, such as any lawsuit in which your health information is relevant to the proceedings. This includes responding to a subpoena or discovery request;

- **Law Enforcement.** Under certain conditions, the Plan may disclose your protected health information to law enforcement officials as part of law enforcement activities, in investigations of criminal conduct or victims of crime, in response to court orders, in emergency circumstances, or when required to do so by law;

- **Coroners, Medical Examiners.** Funeral Directors, and Organ Donation. The Plan may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. The Plan also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties; Further, the Plan may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation;

- **To Prevent a Serious Threat to Health or Safety.** When instances of imminent and serious threat exist as to your health or safety or that of the public or another person, the Plan may disclose your protected health information;

- **Military Activity and National Security, Protective Services.** Under certain conditions, the Plan may disclose your protected health information for specialized governmental functions, such as military, national security, criminal corrections, or public benefit purposes; and

- **Worker's Compensation.** As allowed by Texas law, the Plan may disclose your protected health information to comply with worker's compensation laws and similar programs that provide benefits for work-related injuries or illnesses

- **Disclosure to Family or Others Involved in Your Care**

To the extent authorized by law, the Plan may disclose your health information to your family or other individuals identified by you when they are involved in your care or the payment for your care. It will only disclose the health information directly relevant to their involvement in your care or payment. The Plan may also use or disclose your health information to notify a family member or another person responsible for your care of your location, general condition or status. The Plan will determine whether a disclosure to your family or friends is in your best interest, and then, to the extent allowed by law, it will disclose only the health information that is directly relevant to their involvement in your care.

Except as described above, disclosures of your health information will be made only with your written authorization. You may revoke your authorization at any time, in writing, unless the Plan has taken action in reliance upon your prior authorization, or if you signed the authorization as a condition of obtaining insurance coverage.

BREACH OF UNSECURED PROTECTED HEALTH INFORMATION

You must be notified in the event of a breach of unsecured protected health information. A "breach" is the acquisition, access, use, or disclosure of protected health information in a manner that compromises the security or privacy of the protected health information. Protected health information is considered compromised when the breach poses a significant risk of financial harm, damage to your reputation, or other harm to you. This does not include good faith or inadvertent disclosures or when there is no reasonable way to retain the information. You must receive a notice of the breach as soon as possible and no later than 60 days after the discovery of the breach.

YOUR RIGHTS

THE FOLLOWING IS A DESCRIPTION OF YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION.

- **To Request Restrictions.** You have the right to request restrictions on the use and disclosure of your health information for treatment, payment or health care operations purposes or notification purposes. The Plan is not required to agree to your request (except as described below). If the Plan does agree to a restriction, it will abide by that restriction unless you are in need of emergency treatment and the restricted information is needed to provide that emergency treatment. To request a restriction, obtain the Plan form and submit that form to the Contact Person listed on the final page of this Notice. In addition, you have the right to restrict disclosure of your health information to the Plan for payment or health care

operations (but not for carrying out treatment) in situations where you have paid the healthcare provider out-of-pocket in full. In this case, the Plan is required to implement the restrictions that you request.

- **To Confidential Communications.** You have the right to receive confidential communications about your own health information. This means that you may, for example, designate that the Plan contact you only via e-mail, or at work rather than home. To request communications via alternative means, or at alternative locations, obtain a Plan form and submit that form to the Contact Person listed on the final page of this Notice.

- **To Access and Copy Health Information.** You have the right to inspect and copy most health information about you, including your health information maintained in an electronic format. To arrange for access to your records, or to receive a copy of your records, obtain a Plan form and submit that form to the Contact Person listed on the final page of this Notice. If your health information is available in an electronic format, you may request access electronically or you may request that this information be transmitted directly to someone you designate. If you request copies, you will be charged the Plan's regular fee for copying and mailing the requested information. But, this fee must be limited to the cost of labor involved in responding to your request if you requested access to an electronic health record.

- **To Request Amendment.** You may request that your health information be amended. Your request may be denied under certain circumstances. If your request to amend your health information is denied, you may submit a written statement disagreeing with the denial, which the Plan will keep on file and distribute with all future disclosures of the information to which it relates. To amend any information, obtain a Plan form and submit that form to the Contact Person listed on the final page of this Notice.

- **To an Accounting of Disclosures.** You have the right to an accounting of any disclosures of your health information made during the six-year period preceding the date of your request (three years in the case of a disclosure involving an electronic health record). However, the following disclosures will not be accounted for:

- Disclosures made for the purpose of carrying out treatment, payment or health care operations (Note: Does not apply to electronic health records.);
- Disclosures made to you;
- Disclosures of information maintained in the Plan's patient directory, or disclosures made to persons involved in your care, or for the purpose of notifying your family or friends about your whereabouts;
- Disclosures for national security or intelligence purposes;
- Disclosures to correctional institutions or law enforcement officials who had you in custody at the time of disclosure;
- Disclosures that occurred prior to April 14, 2003;
- Disclosures made pursuant to an authorization signed by you,
- Disclosures that are incidental to another permissible use or disclosure; or
- Disclosures made to a health oversight agency or law enforcement official, but only if the agency or official asks the Plan not to account to you for such disclosures and only for the limited period of time covered by that request.

- The accounting will include the date of each disclosure, the name of the entity or person who received the information and that person's address (if known), and a brief description of the information disclosed and the purpose of the disclosure. To request an accounting of disclosures, obtain a Plan form and submit that form to the Contact Person listed on the final page of this Notice.
- **Right to a Paper Copy of this Notice.** You have the right to obtain a paper copy of this Notice upon request.
- **Law Pertaining to Notice.** The Plan is required by law to maintain the privacy of protected health information and provide the individual with notice of legal duties and privacy practice with respect to the information. The Plan is required to abide by the terms of this Notice as it is currently in effect.
- **Amendment to Notice.** The Plan reserves the right to revise, amend, and change this Notice and the Plan can make the changes, revisions, and amendments effective for all protected health information that the Plan maintains. A revised notice will be distributed to all Plan participants within sixty (60) days after the revision, amendment, or change.

Effective April 20, 2005, the City Employee Health Benefits Plan (the "Plan") conforms with the requirements of the Security and Privacy requirements of the Health Insurance Portability and Accountability Act ("HIPAA Security Rule"), by establishing the extent to which the City (the "Employer") will receive, use, and/or disclose Electronic Protected Health Information ("EPHI").

Employer's Requirements for Safeguarding EPHI. EPHI will be safeguarded as follows:

- The implementation of administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI created, received, maintained, or transmitted by the Employer on behalf of the Plan. These administrative, physical, and technical safeguards are implemented through the adoption of HIPAA Policies and Procedures.
- The Plan is allowed to disclose to the Employer information on whether the individual is participating in the Plan, or is enrolled in or has dis-enrolled from a health insurance issuer or HMO offered by the Plan. Except for such authorized disclosures, the Employer is required to ensure that adequate separation exists between the Employer and the Plan through the implementation of reasonable and appropriate security measures.
- The Employer must ensure that any agent, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect EPHI.
- The Employer is required to report to the Plan any security incidents of which it becomes aware.

Exceptions to Employer's Safeguarding of EPHI.

The Employer will reasonably and appropriately safeguard EPHI created, received, maintained, or transmitted to or by the Employer on behalf of the Plan, except as disclosed pursuant to:

- A request for summary health information to obtain premium bids from health plans for providing health insurance coverage under the Plan or modifying, amending, or terminating the Plan.
- A request for information on whether the individual is participating in the Plan, or is enrolled in or has dis-enrolled from a health insurance issuer or HMO offered by the Plan.

- The following HIPAA Policies and Procedures:
- Uses and Disclosures of PHI Based On Patient Authorization;
- Uses and Disclosure of Psychotherapy Notes;
- Uses and Disclosure of PHI for Marketing;
- Revocation of Authorization to Release PHI; and
- Authorization Form.

COMPLAINTS

You may complain to the Plan if you believe that we have violated your privacy rights by completing a complaint form obtained from the Privacy Officer, Margaret Wise. You may also complain to the Secretary of the Department of Health and Human Services. No action will be taken against you for filing a complaint.

DESIGNATED CONTACT PERSON

Margaret Wise, the Privacy Officer, is the designated contact person for the Plan. You can contact her at 817-392-8058

ABOUT THIS GUIDE

This guide highlights your benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual summary plan descriptions (SPDs), plan document or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail. The City of Fort Worth reserves the right to make changes at any time to the benefits, costs, and other provisions relative to benefits.

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FORT WORTH®